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More than 170 key representatives of nursing, allied health and education professions, government agencies, regional and state planning groups, and other citizens participated in the conference, which sought to answer the questions: (1) What is community planning? (2) Who does it? and (3) How does community planning for nursing relate to overall planning for health services and education? Speeches include: "Citizen Planning for Nursing," by Edwin F. Rosinski, "The Virginia Study" by Mabel E. Montgomery, "State-Wide Planning in North Carolina" by Howard R. Boozer, and "Comprehensive Community Nursing--Chaos or Challenge" by Dorothy L. Barfield. Regional advisory teams suggested nursing service and nursing education issues to state groups for discussion. Groups representing Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, and West Virginia formulated statements of concern and commitment including action steps which they, as unofficial groups, hoped to take within a month after returning home. Discussions and plans are summarized. (JK)

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OPERATION DECISION:

CITIZEN PLANNING FOR NURSING IN THE SOUTH

REPORT OF A CONFERENCE

Sponsored by

SOUTHERN REGIONAL ASSEMBLY OF CONSTITUENT LEAGUES FOR NURSING

and

NLN COUNCIL OF PUBLIC HEALTH NURSING SERVICES

Atlanta, Georgia

March 6-8, 1968

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INTRODUCTION

Spring was just edging in on the South when the National League for Nursing held its second of a series of regional conferences to stimulate community planning for nursing in Atlanta, Georgia, March 6, 7, and 8, 1968. Few approaches to solving nursing's problems in recent years have attracted such widespread attention as has community planning. Few approaches also have had such a wide variety of applications or depended so on who takes the leadership and what is being done by other segments of the health community.

<u>What</u> is community planning?

<u>Who</u> does it?

<u>How</u> does community planning for nursing relate to overall planning for health services and education?

It was to answer such questions as these that the Southern Regional Assembly of Constituent Leagues for Nursing and the NLN Council of Public Health Nursing Services joined hands to sponsor this conference. Specifically to answer the question "Who?" the planning committee adopted the title of the conference: "Operation Decision: Citizen Planning for Nursing in the South."

More than 170 key representatives of nursing, allied health and education professions, government agencies, regional and state planning groups, and citizens came to Atlanta for the conference. They came to learn, to share experiences one with the other, to project tasks that need to be undertaken in the individual states, and to find out what planning operations are already underway or on the drawing boards. All 13 of the Southern states, Puerto Rico, and the Virgin Islands were represented. State governors sent official representatives.

For two of the three days they worked together in group and team sessions.

In one type of grouping, a cross section of people from the various states, activities within nursing, and planning operations formed regional advisory groups to identify issues in nursing service and education. Their task also was to ascertain the data

available and needed in order to come to grips with the issues and to analyze the potential for doing so. It was no happenstance that the dual demands on nursing for more and better nursing services rang steadily through their projections.

Special interest groups were charged with another responsibility -- to set down points of view, the needs of their areas of nursing education and patient care, and specific recommendations which planning groups should take into consideration in charting action programs in the states. There were special interest groups representing associate degree programs in nursing, baccalaureate and higher degree programs, continuing education, diploma programs, inservice education, nursing services, state boards of nursing, and vocational/practical nursing.

Specific planning responsibilities were then assumed by state teams, using as resources their own knowledge of the nursing and health care situations in their states, the ideas and recommendations of the speakers, regional advisory and special interest groups, and other resources made available to them.

Ideas came in the opening conference address by Edwin F. Rosinski, Ed.D., deputy assistant secretary for health manpower, Office of Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare; in the reports of two state planning operations in the South by Mabel E. Montgomery, member of the Virginia Governor's Committee on Nursing, and Howard R. Boozer, director, North Carolina Board of Higher Education; in a luncheon address by Dorothy L. Barfield, chief coordinator, nursing services, Georgia Department of Public Health; and in a report of the activities of the Southern Regional Education Board by Helen Belcher, its nursing project director. Pertinent data and other materials were furnished each conference registrant, and the participants themselves brought materials to share.

Thus armed, the state teams -- one for each of the 13 states -- worked to develop plans of action. On "IMPACT" sheets prepared especially for use by individual participants they captured ideas as they were offered, transferring these as needed to newsprint or blackboard for group consensus, refinement, and synthesis. The sheets were a ready reminder of the participants' responsibilities as conferees to:

I -- identify issues
M -- mobilize data
P -- project needs
A -- advance proposals
C -- coordinate resources
T -- take action

As interaction grew among the participants, so recommendations for action grew. By the final day of the conference state teams were able to write out statements of concern and commitment. So precise had their hopes for and knowledge about nursing in their own home states become by this time that state teams were able to include in these statements the action steps they, as unofficial groups, hoped to take within a month after returning home.

The discussions and plans of each state team are briefed in this report. The nursing service and education issues identified by the regional advisory group and the conference papers which started the participants off in their deliberations are reported in full.

The conference planning committee (see page 55 for the composition of this committee) adapted the Atlanta conference plan from earlier NLN regional meetings, "Operation Decision: Community Planning for Nursing in the West," held in January and November, 1967, in Las Vegas, Nevada.

The conference was under the direction of Margaret B. Harty, Ed.D., director of nursing education for the National League for Nursing.

Some 30 of the participants served also as conference facilitators. They were the state team leaders, either presidents or appointed representatives of the state constituent leagues in the South; the special interest group leaders and the regional advisory group leaders, each an expert in his or her field.

The Atlanta sessions concluded with the annual meeting of the Southern Regional Assembly of Constituent Leagues for Nursing. In this reorganization meeting the regional assembly adopted rules of procedure and took other appropriate action to conform to new bylaws adopted by the NLN membership in 1967. Since this was a business meeting, its proceedings have been issued separately. The assembly's meeting, however, was integral to the conference in that it utilized the assembly as the mechanism through which the various activities and projects initiated by the states can be welded into regional action for nursing in the South.

O P E N I N G A D D R E S S

CITIZEN PLANNING FOR NURSING

by

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All health professions have as their immediate goal the health needs of society. Professional groups may have different interpretations of how the needs will, or can, be met; nevertheless, all have two common denominators in their ultimate goal -- health and society.

The health professions are willing to concede that they must adjust to differing societal health needs. All are alert to the obvious fact that the health needs of the Park Avenue matron may be different from those of the middle class suburbanite, or the rural farmer, or those of the socially and economically disadvantaged living in urban ghettos or grubbing out an existence on a marginal farm. While good health is the goal of all of these, what constitutes good health depends on a number of factors including individual expectations and individual values.

With this tremendous disparity between the needs from one individual to another, the health professions have before them a task of gargantuan proportions. Since the professions must be geared to accommodate such wide variations in needs, it is miraculous that so much has been accomplished by them.

While the nation can point with pride to its achievements, we still fall short of fulfilling the health goals we have set for ourselves. The reason we have not been able to meet the health needs of our society to a greater degree is that we have lacked one essential resource -- manpower. We have compounded our difficulty by not using efficiently the limited manpower we possess. If the health needs of society are to be met, considerable emphasis will have to be placed on the production and efficient use of our health manpower resources.

Obviously, if the delivery of health care is to be improved, a cadre of health workers, representing various competencies, must

be mobilized. Within this cadre, nurses must play an integral and dominant role. It is a role for which nurses are ideally suited by tradition and education. But unless some marked changes occur in nursing, the leadership will slip away from it and be assumed, by default or usurption, by others. Unless nursing goes through a critical soul-searching analysis and arrives at practical solutions, it will find itself falling from its lofty perch.

Nursing has already lost much of its sheen, grandeur, and image -- lost it because of a number of factors, not the least of these the intransigence of the nursing profession itself. All of you will not agree with me. I may arouse hostile attitudes in some of you. But you did not invite me here to tell you that all is well and that you should sit back to collect and meditate on your laurels. My hope is to be critically constructive by giving you a series of challenges as a starting point for your deliberations. I appreciate that this audience consists of individuals other than nurses. This is as it should be, for to solve the problems of health manpower will require the combined efforts and abilities of all community leadership groups.

I preface my challenges with a concept, a notion, a goal that is dear to all of us -- quality. The word "quality," unfortunately, is used often as a smoke screen to obscure vested interests. Quality also is often used synonymously with credentialling. Unfortunately, credentialling can lead to a closed professional system. Within this closed system ritualistic, prescribed, and often arbitrary standards are set -- standards which do not necessarily assure quality, but which can restrict quantity. We want to make sure that quality is maintained, especially in the delivery of health services. Criteria of quality, however, first must be defined before educational standards are established.

Society today seems preoccupied with symbols, and the health professions are especially guilty of the pursuit of symbols. One can question legitimately whether baccalaureate degree nurses, by virtue of possessing the symbol of the degree, can provide a better quality of patient care than can graduates of diploma schools or junior colleges. The differentials in their educational backgrounds will provide them with varied basic knowledge and skills so that each can move along different tracks. But since quality of patient care has not yet been defined adequately, I am at a loss to uncover significant data documenting quality differences between the functions of various groups of registered nursing personnel. Individual cases, no doubt, can be cited, but differences can also be documented within a group. Graduates of collegiate programs run from good to bad, as they do for diploma and two-year programs. However, marked distinctions between the groups, based on the measure of quality of patient care, have not been presented. Too often

decisions are based on an emotional and personal response; such emotionalism surrounds the issue of quality when nursing education is discussed.

The fundamental issue of credentialling and standards in nursing education restricts the nursing profession from fulfilling its real promise. The pursuit of ill-defined goals has so preoccupied nursing educators as to dissipate and dilute their energies and talents. These energies and talents could be directed better toward alleviating the manpower crisis and meeting the health needs of our communities.

Just where should these talents be directed? A number of challenges must be met and programs undertaken, by both the community and the profession, if the health needs of society are to be met. None of these efforts individually will make an appreciable dent in our nursing needs, but if undertaken as a combined effort they will begin to make inroads into the nursing personnel shortage.

The first challenge is that nursing must be made more attractive as a profession. As an essential start, working conditions and wages must be improved. No longer can we recruit high school students into nursing schools by describing the altruistic values of serving mankind, engender this same humanitarian spirit in them while nursing students, and then upon graduation send them out to the harsh, real world where the professional nurse, if she is fortunate, may earn almost as much as a New York City garbage collector! If it were not enough that salaries are marginal, the young nurse often works under conditions which Samuel Gompers would have considered less than satisfactory in a sweat shop. Under such circumstances, even the most noble of intentions quickly disappear. What should surprise the public is that as many individuals as do so continue in nursing. They indeed must be motivated by a spirit of humanitarianism. No one has ever become independently wealthy at an early age by being a nurse.

The community must become acute to the problems associated with poor pay and poor working conditions. The profession, in turn, must make its needs known to the community. Only the profession can make the public aware of its needs. If the leadership group in nursing would spend as much time pursuing better salaries and working conditions as in pursuing nebulous standards, the plight of nursing might not be as grave as it is now. There is nothing wrong in being militant within reason to meet goals. Why not be more militant in seeking good pay and working conditions?

The community cannot remain deaf to the needs of nurses. It wants dedicated nurses, but it must be aware that dedication is

entitled to reasonable material rewards.

If nursing becomes a more attractive career, recruiting able students into the profession can be done with a clearer conscience. Nursing schools are not attracting enough students. This has been attested to by the Southern Regional Education Board and various state studies. We need to recruit far more students into the profession. Again, this cannot be left solely in the hands of the profession. The community and the profession must forge a partnership to attract students into nursing careers. Schools of nursing, almost all of which are understaffed, cannot be expected to educate students and at the same time launch major campaigns to recruit applicants. This calls for community action.

The profession, however, can do its part to make nursing a career that will appeal to segments of the population it has not reached so far -- specifically, men and students from educationally disadvantaged groups.

Many people who have studied nursing hypothesize that many of its problems could be corrected if more men entered the profession. As an example they point to the teaching profession which since World War II has attracted more men and as a corollary improved its status. In the health field physical therapy each year attracts more men into its ranks and at the same time improves and asserts its status. With all their wonderful attributes, women are just not as aggressive as men. The male must be more aggressive. He has a wife and children to support, usually a mortgage on a house, and the prospect of sending his children to college. For survival, and for his and his family's well-being, he must be aggressive in the best sense of the word. Nursing would benefit significantly by having more men in its ranks. Men also represent an untapped pool of possible nursing school applicants. This pool cannot be tapped unless nursing takes a fresh look at itself as a career and improves its educational image.

The next challenge I offer is directed toward nursing's image. While the profession is most intimately concerned with this challenge, the community must be aware of it and actively involved in meeting it.

For most practitioners nursing is a terminal career. Although a nurse may become a psychiatric nurse, surgical nurse, nursing supervisor, or dean, by and large her duties will center around nursing, with only the degree of the nursing responsibilities changing. Nursing needs to examine the possibility of developing new career models centering around nursing. I suggest that the nursing profession take leadership in developing these new career models. If the profession is reluctant to assume the initiative,

it should at least participate in the development of new models.

What does the term "new careers" mean? Generally, it means that an individual who has the ability and motivation may begin a career as a practical nurse, work several years in this capacity, and then be given credit for past education and experience to become a registered nurse without going through the full course of rigid RN classroom requirements. The present preoccupation with credentialling again precludes this occurring. The new career concept goes even further than this, however. An RN, whether her title is acquired directly or through career mobility, should also be able to capitalize on past experience and training to move up the career ladder. To accomplish this will require the creation of new levels of health personnel which are not now in existence.

Significant inroads have been made in the creation of new levels of health personnel. New careers in health into which RN's can move as a rule have been opposed by the nursing profession. For instance, the categories of health workers which appear most appropriate for nurses to move into, such as physicians' assistants and pediatric assistants, have received little support. The argument is that if such career opportunities were available to RN's, the ranks of nurses would be depleted further.

My point of view is that if greater career mobility were available, more students would be attracted to and retained in the health field. I believe that nursing as a career would be enhanced if a nursing student knew that ability and interest could move her in an upward and lateral direction to a number of careers related to patient care. I use "patient care" deliberately for I view the new careers as moving away from simple nursing to more sophisticated patient care carried out as a member of the physician's health team. I do not advocate that everyone follow this route; I merely suggest that this route, or a number of routes or options -- more than are now available -- should be open to both students and practitioners.

More men will not be recruited into nursing unless nursing has more to offer in the way of options for career mobility. Nursing cannot remain blind to the development of new levels of health personnel much longer. Most reports dealing with health manpower recommend that new levels of health personnel be created. Private foundations are actively supporting this approach and many have made financial commitments to institutions and agencies developing new health personnel programs. Nursing leaders and the community must face the reality that the image of nursing education can and must be improved through the development of models of new levels of health personnel that allow for upward and lateral career mobility.

My next challenge is also related to men in nursing. Last year the Department of Health, Education, and Welfare, in conjunction with the Department of Labor, instituted a program called "Project Remed." The goal of this project is to recruit into civilian health occupations a portion of the 70,000 servicemen discharged annually who have had medical corps training in military service. Seventy thousand men a year -- what a tremendous potential pool of civilian health personnel!

Project Remed has been successful when veterans elect to go to school for additional education. With those who wish to enter a job immediately, it has been less successful. A typical example is that of a young man who wrote a letter which crossed my desk recently. This young man had been in the service for four years. He tended to the health needs of an entire village in Vietnam. He was the only source of medical care for all of the men aboard a small naval vessel. He served in stateside military hospitals and performed his duties with remarkable skill and efficiency. Physicians attested to his ability; one said, "I would rather have him than three nurses."

On his return to civilian life he decided to enter a health job immediately. He wanted to be a nurse. Because he was only a high school graduate and had had no civilian health service training, the only door open to him was to become an orderly. An orderly, not even a practical nurse!

Here we are in a health manpower crisis with 70,000 potential trained health workers available, and we do not use them. Why does nursing not actively pursue the possibility of equivalency examinations which, if passed, or perhaps with an additional year of formal education, could qualify one to become an RN? This is a challenge to nursing educators. Why not the possibility of state licensing boards developing examinations to test the competency of such individuals? This is a challenge to state agencies. Why do hospitals not create new positions in their manpower systems to accommodate these highly skilled individuals? This is a challenge to hospital administrators. Voluntary health agencies and educational organizations all have a stake in this issue. Make this issue your cause as well.

Another challenge is that of making greater innovations in educational programs. The educationally disadvantaged represent a potential pool of applicants to nursing schools. These individuals cannot enter nursing while rigid admissions standards persist. Schools of nursing must take the initiative in developing collaborative programs with state vocational education agencies, high schools, and other educational institutions to upgrade the educational background of the disadvantaged. Nursing schools

which do not have the resources must turn to the community to assist them in the creation of such programs.

Medical schools are currently experimenting with various curricula. Some medical schools have combined college and medical school into a six-year sequence, some have done away with the internship, and others have allotted almost one-half of the student's time to electives. If medical educators can experiment with their educational programs, why not nursing educators?

Nursing is in a unique position to develop truly innovative programs. Perhaps it could capitalize on its three different levels of registered nursing education by developing each as a distinctly different program producing individuals to meet distinctly different professional and societal needs. Nursing education already has a great deal of flexibility. Use that flexibility to advantage.

Core curricula, joint programs with other comparable health professionals, programs for the disadvantaged, special programs for upgrading allowing for past experience and training -- these are the innovations nursing could institute in its educational system. Such programs should be planned by communities on a regional basis. We have tended in the past to approach our efforts piecemeal, centering them in so-called centers of excellence. The products of these centers seldom gravitate to other smaller communities. These communities have become statistics in what is referred to as maldistribution of health personnel. The South is most familiar with this situation. Community planning to develop innovative educational programs may not solve the nursing problem, but they would go a long way toward reducing it.

The nursing shortage will not be relieved unless we make more efficient use of nursing personnel. This is my next challenge. It is fashionable today to be a proponent of research on more efficient use of health personnel. Yet, after the words of endorsement and the platitudes that go with this highly desirable activity are cleared away, surprisingly little has been, or is being, done. We have not even begun to explore such areas as what are the best staffing patterns, what are the best ways to allocate duties, and what new levels of health personnel can best assume existing and new responsibilities. Nursing must give priority to well-designed and expertly carried out studies of this kind.

Here is one example of the types of studies I see as necessary. A large metropolitan hospital conducted a straightforward study of how registered nurses perceive the delivery of care by nursing personnel. The study team identified 81 services rendered to acute patients and then asked the RN's which of the 81 services could be performed by the three groups of nursing personnel: RN's, LPN's,

and those with grade or high school education and six months of on-the-job training. The RN's agreed that only nine of the 81 services required a registered nurse.

We know we are using our nursing personnel inefficiently because many of us feel it. We need more hard, cold data of the kind derived from this study in order to make the health manpower system more efficient. Unless we make far better use of nursing personnel, all the gains we make in increasing numbers will be in vain.

This kind of research will require the cooperation and assistance of physicians, hospital administrators, and other health personnel. Nurses, however, should be responsible for assuming much of the leadership in initiating utilization studies.

My final challenge is a personal one -- for a change of attitude on the part of all who are concerned with the delivery of health care. A spirit of change is permeating the health field. New levels of health personnel are being created. New ways to provide care are being instituted. Old ways are being discarded. Redefinitions are being presented. New demands are being made, and old demands are being reinforced. How the health occupations, especially the tested professions, react to these changes will tell us how the health needs of society will be met.

The first natural reaction is to resist the change. I sense that nursing feels threatened by the changes that are occurring. Years ago the health occupations could be described as stable. That stability no longer exists. New demands are being made on all of us to meet the health needs of our citizens. If the existing system cannot deliver it, then the system must be changed. Nursing, especially its leadership group, must help modify the existing system. If modification does not work, then nursing must be instrumental in developing a new system. Twenty years ago there was a popular song called "Everything is Moving Too Fast." If things were moving too fast then, what is the rate of speed now?

In planning for nursing in the South then, there are many challenges that must be accepted and met. I have enumerated a few. In summary, these are:

1. Quality of nursing and nursing education must be maintained, but the application of prohibitive and restrictive standards under the guise of quality has no place in our society.

2. Salaries and working conditions must be improved.

3. Far greater effort to recruit students into nursing must be exerted.

4. More men must be attracted into the profession.

5. Innovative educational programs, including those for the educationally disadvantaged, must be developed.

6. Greater career mobility must be provided. If this calls for the development of new levels of health personnel and equivalency examinations, so be it.

7. Research on more efficient use of personnel must be carried out.

8. The results of promising research must be applied.

9. Attitudes must be altered so that nursing is more receptive to the changes that must be made.

While I may seem to have been critical of nursing, my intention has been to be constructive. Other health disciplines can be criticized equally. I have given you some challenges to which you can address yourselves. They are challenges I am confident nursing can meet.

T W O S T A T E P L A N S F O R N U R S I N G

THE VIRGINIA STUDY

by

Mabel E. Montgomery

Secretary-Treasurer, Virginia Board of Nurse Examiners
Member, Virginia Governor's Committee on Nursing

In its report to the Governor in late 1965, the Virginia Commission on Higher Education emphasized the need for a coordinated effort to solve the nurse shortage in the state. It recommended that a study be made of the factors contributing to the shortage and the means of alleviating it.

The committee which Governor Godwin appointed in the latter part of 1966 to undertake this responsibility is known as the Governor's Committee on Nursing. This committee is a representative one. Its membership of fifteen consists of representatives from various groups interested in and concerned with nursing. Five registered nurses are on the committee.

Governor Godwin charged the committee to look at the following factors:

1. The need for nurses in the state, with projections for the next 10 years.

2. The types of education programs needed and the auspices under which each should be offered in order to provide an adequate and qualified supply of several classifications of nurses essential to meet future needs of the Commonwealth.

3. Attracting students into nursing education programs in sufficient numbers to meet state needs.

4. Returning to the profession qualified nurses who are not now practicing and whose skills could help relieve existing shortages.

Since its appointment, the committee and its executive

committee have held a number of meetings to consider the many issues related to nursing and the manner in which these issues should be considered.

The committee established contacts with agencies, organizations, and individuals within the state of Virginia and throughout the nation, soliciting information and guidance for its assigned work. One of the first organizations approached was the Southern Regional Education Board. A subcommittee sought from SREB both assistance in planning and information on current and recent developments related to nursing and nursing education in the Southern region and throughout the nation. SREB was extremely helpful, especially in advising the committee that:

1. No model state study existed which could be recommended to the Virginia study group as a pattern.

2. Every effort should be made to relate the nursing study to other major planning activities being conducted in various phases of health care.

3. A comprehensive period of time -- as much as two years -- and more financial support than had been initially contemplated should be sought.

Even before a study director was found, the committee surveyed agencies and organizations for materials and resources and inventoried available statistical data concerning nurses and nursing in the Commonwealth obtainable from state agencies.

In May, 1967, William K. Selden of Princeton, New Jersey, was appointed director of the study.

Following his appointment Mr. Selden wrote to the directors of schools of nursing and to the executive officers of associations and organizations in the state concerned with health care. From these he sought both information and suggestions for the conduct of the study. Personal interviews were also held with as many of these people as possible.

Mr. Selden made similar contacts with officials of regional and national organizations involved in health care. He consulted with many people in the United States Public Health Service, other Federal government agencies, and leaders in providing and planning health care.

Next, the committee prepared a study outline. They agreed this outline must be flexible. All items may not be included in the committee's final report and other items may be added to the study.

A request was made to Governor Godwin for an extension of time for the study as recommended by SREB. The committee recognized this as essential if a worthwhile study were to be made. This request was approved by the Governor.

In December, 1967, a progress report containing the study outline the committee proposed to follow was presented to the Governor. The report emphasized again that the outline projected the information and material the committee hopes to assemble, not the final report.

Since then Thomas Barker, director, School of Hospital Administration, Medical College of Virginia, has been appointed as associate director of the study in charge of research. He is involving his students in the study and providing them with an unusual learning experience.

The proposed pattern and timetable for the Virginia study is as follows:

1. A conference on future patterns of health care, with emphasis on utilization of nursing personnel, is to be held this month in Williamsburg. Approximately 100 persons have been invited to participate.

   The Conference has been made possible by a grant of $17,500 from the Old Dominion Foundation and will be jointly sponsored by the Governor's Committee on Nursing, the Medical Society of Virginia, the Virginia Hospital Association and the Virginia Nurses' Association. A number of well-known people from other states have been invited to participate in the conference as resource persons.

   A list of topics or questions has been prepared for study and consideration in five discussion groups at the conference. Brief reports from these groups will be made to the entire group on the last day of the conference.

   A detailed report of the conference will be distributed widely throughout the state and, it is hoped, will assist the committee in reaching its conclusions.

2. A compilation of factual and statistical data on nursing in Virginia is to be completed and the assembled material issued in September, 1968.

3. Two public hearings are to be held by the committee in

Richmond and Roanoke in the fall of 1968. Representatives of organizations and interested individuals may present testimony, opinions, and recommendations for consideration by the committee.

4. The final report including conclusions and recommendations of the Governor's Committee on Nursing is to be submitted by early spring of 1969. This report will have wide distribution in the state prior to the 1970 session of the General Assembly.

In view of the involvement of nursing in all aspects of health care, the committee not only is cognizant of the intimate relationship that nursing bears to each of the health professions but also believes that it is essential for it to engage in joint deliberations and cooperative study with all of these groups, in order that a coordinated approach may be pursued for improved health care in the future.

STATE-WIDE PLANNING IN NORTH CAROLINA

by

Howard R. Boozer, Director
North Carolina Board of Higher Education

For the past year and a half we in North Carolina have been involved in a nursing education planning study. This is the third state survey of nursing education since World War II. The first was sponsored by the University of North Carolina and the North Carolina Medical Care Commission. The report, "Nursing and Nursing Education in North Carolina," was published in 1950. The second, directed by Ray E. Brown, then of Duke University, was published in 1964 under the sponsorship of the State Board of Higher Education, the Board of Education, and Medical Care Commission as the "Report of Survey of Nursing Education in North Carolina."

Several factors precipitated the 1964 survey. One was that the major producers of nurses in the past, hospital diploma schools, had decreased from 43 to 25 in less than 15 years. At the same time, there was growing recognition that nursing education is a legitimate responsibility of higher education institutions, and several new baccalaureate nursing programs had been established. Also, the new pattern of associate degree nursing education in two-year colleges was emerging and gaining acceptance.

In the 1964 study Ray Brown recommended that a continuing joint committee on nursing education be established by the State Board of Education and the North Carolina Board of Higher Education to carry out the study proposals.

Joint Committee on Nursing Education

By January, 1965, the two Boards (one of which is concerned with the public schools and community colleges and the other with senior colleges) had appointed the Joint Committee on Nursing Education. The membership includes representatives of all types of nursing education programs as well as others in and outside the health-related professions. The groups represented are the North Carolina League for Nursing, the North Carolina Board of Nursing, the North Carolina Board of Higher Education, the State Board of

Education, the State Department of Community Colleges, the North Carolina Hospital Association, the Medical Society of the State of North Carolina, the North Carolina State Nurses' Association, and several institutions which conduct nursing education programs in the state.

The committee initially limited its concern to nursing programs preparing graduates to take the licensure examination to become registered nurses. In September, 1965, the State Department of Community Colleges requested that the committee include practical nursing education. Thus the whole spectrum of nursing education has become the concern of the committee.

A subcommittee was appointed to maintain liaison with similar committees of other interested organizations in North Carolina. There are five other state-wide nursing education committees in addition to the joint committee. These are:

1. Advisory Committee on Nursing Programs of the Department of Community Colleges, State Board of Education.

2. Special Committee on Education for Nursing in North Carolina of the North Carolina State Nurses' Association and the North Carolina League for Nursing.

3. North Carolina Committee on Patient Care.

4. Committee of Physicians on Nursing of the Medical Society of the State of North Carolina.

5. Council on Nursing of the North Carolina Hospital Association.

The subcommittee brought all of these committees together for discussion of their origins, purposes, scope, and planned activities. The subcommittee's first newsletter reported the information gained from this discussion.

Another subcommittee has also met with representatives of several colleges and universities, and communities, to learn of their plans to initiate nursing education programs.

Recommendations for Legislative Action

The joint committee's usefulness as a means of bringing together various health-related professions for action was first illustrated in the summer of 1966. A special study committee of the Legislative Research Commission of the North Carolina General Assembly requested that the joint committee develop recommendations

for legislative action to help alleviate the shortage of nurses which could be supported by all concerned groups. Until this time there had been no unanimity among the various health-related organizations. The legislators were confused, if not frustrated. The Joint Committee on Nursing Education convened a meeting of concerned organizations and agencies.

By the end of September, 1966, recommendations for legislative action to which all could subscribe had been unanimously endorsed by formally designated representatives of the diverse state health and related organizations and agencies, by the Joint Committee on Nursing Education, by the State Board of Education, and the Board of Higher Education. These were transmitted to the chairman of the legislative study committee. The recommendations were that

1. Approval be given to budget requests for all existing types of state-supported nursing education programs.

2. Funds be appropriated to assist existing diploma nursing education programs.

3. Additional funds be appropriated to the School of Nursing at the University of North Carolina, Chapel Hill, to permit expansion of continuing education programs.

4. Increased funds be made available to the scholarship-loan fund administered by the North Carolina Medical Care Commission.

These recommendations led to the introduction of a bill in March, 1967, which resulted in an appropriation of $300,000 for the 1967-69 biennium to the State Board of Education to provide financial assistance to diploma nursing programs. To qualify for this assistance a program must be conducted by an educational unit in nursing fully approved by the North Carolina Board of Nursing and operated by a public or nonprofit hospital licensed by the North Carolina Medical Care Commission.

The State Board of Education through the Department of Community Colleges distributes these funds to eligible diploma nursing programs, upon their application for assistance, on the basis of $100 per student enrolled in the programs as of December 1 of the preceding year. The State Board of Education has established rules and regulations to insure that the financial assistance is used directly to upgrade the instructional programs (faculty, curriculum, books, materials, etc.) of the diploma schools.

State-wide Study of Nursing Education

Our state-wide study of nursing education, under the auspices of the Joint Committee on Nursing Education, was undertaken in May, 1966, concurrently with a number of other Board of Higher Education long-range planning studies.

The study was done in two parts. Phase I was largely an updating of the statistics in the 1964 study: the number of nurses, where they are employed, their educational attainment, migration and attrition, geographic distribution, and other characteristics of nurses such as age, sex, race, and marital status. Phase I also dealt with the characteristics of nursing education programs and students in North Carolina: types and locations of programs, trends in student admissions and graduations, student and graduate characteristics, and student attrition.

Phase II was essentially interpretive. Analyses were made of the average daily census and the range of services and facilities available in hospitals which are used for clinical experience by nursing education programs in the state. Analyses were also made of the qualifications of faculty and the performance of graduates on licensure examinations, in terms of the clinical resources (average daily census and range and number of services) used by the different types of nursing education programs.

The report also considers factors affecting the demand for nurses, such as changing responsibilities and new career patterns. It includes projections of future demand for nurses, student potential and recruitment, and the capacity or plans of present programs to expand. After stating several assumptions concerning the future, the report concludes with recommendations for the further development of nursing education in North Carolina.

The assumptions for the future are that

1. Working conditions of nurses will improve.

2. Nursing education programs will improve.

3. Recruitment of students into nursing education programs will increase.

4. The output of nursing education programs will increase.

5. The return of inactive nurses to the profession will increase.

6. The responsibilities of nurses will continue to change.

On the basis of these assumptions, the report recommends that

1. Student recruitment be intensified.

2. Enrollment in adequate programs be expanded.

3. Inadequate programs be upgraded.

4. Continuing education and refresher course programs be expanded.

5. Programs with 50 percent of graduates failing the licensing examination over a period of three years be phased out.

6. Graduate nursing education programs be expanded; however, master's degree programs should be undertaken only in institutions having strong baccalaureate programs.

The recommendations of the report concerning minimum standards are that

1. Hospital clinical resources should be sufficient at the various levels of nursing education to maximize exposure of students to a variety of patients and existing nursing situations. Practical nursing education programs should use a hospital with at least a minimum daily average census of 60 patients and at least four services -- an operating room, a delivery room, a clinical laboratory, and diagnostic x-ray.

   Diploma or associate degree programs should use a hospital with an average daily census of 150 or above, with 7 or more facilities.

   Baccalaureate programs should use hospitals with an average daily census of 300 or above and with 12 or more facilities.

2. Enrollment in a nursing education program should insure a ratio of at least five patients to each student receiving clinical experience <u>in a given area</u> or department of the training hospital <u>at a given time</u>.

3. Only in unusual circumstances should one hospital be used simultaneously by more than one program for registered nurses.

4. No program should be established in the absence of the availability of a primary hospital meeting the criteria on size and facilities.

5. The educational attainment of a faculty member should be at least one level more advanced than the level of nursing which she teaches, but not less than a baccalaureate degree.

This study was the work of many interested and concerned persons. Among those who provided research, statistical, writing, and editing services were E. S. Lee, of the Board of Higher Education staff, and Mrs. Ida Harper Simpson, a sociologist at Duke University, who prepared the initial draft. Members of the Joint Committee on Nursing Education carefully reviewed several drafts. Dr. John F. Corey, an assistant director of the Board of Higher Education, and Margaret Moore of the School of Nursing of the University of North Carolina, Greensboro, and a member of the Joint Committee, edited the final report.

Although this study was undertaken as one of a number of the long-range planning studies of the Board of Higher Education, state funds were not appropriated to underwrite it completely. To assist the board in the employment of a consultant, the following groups contributed $1,800 as tangible evidence of their interest, support, and cooperation: the North Carolina League for Nursing, North Carolina Board of Nursing, North Carolina State Nurses' Association, North Carolina Hospital Association, and the Medical Society of the State of North Carolina. All other costs -- staff time, clerical assistance, printing and distribution of the report -- have been borne by the North Carolina Board of Higher Education.

Conclusion

We hope that our experience in state-wide planning for nursing education will be helpful to others. There have been some pluses and some minuses in our approaches and procedures. To those who are about to initiate state-wide planning for nursing education in your state, I recommend that you

1. Involve representatives of the major health-related professions (e.g., nursing education and nursing service, physicians, hospital administrators, etc.), representatives of official agencies having

responsibility for nursing and nursing education, and several educators who are generalists. We have a committee composed of such persons, and the members have come to work well together over the past several years in attacking the shared problem of meeting the health needs of the citizens of the state.

2. Arrange for adequate financing. This was a weakness in our study. Except for one part-time paid consultant, the work was done by regular staff members of the Board of Higher Education who also have many other duties and responsibilities, and by members of our joint committee who have their own full-time commitments elsewhere.

3. Appoint an advisory committee of out-of-state consultants, to supplement your in-state committee. We had a panel of excellent out-of-state consultants in the 1964 study and they were most helpful. The absence of such an advisory committee in our most recent study was a weakness.

4. Secure the best qualified persons available to direct and assist in the studies.

5. Make full use of available information and statistics. The U. S. Public Health Service, the State Board of Nursing, the nursing associations, and other agencies and organizations such as the Southern Regional Education Board have much helpful information. Pulling together in a meaningful way what is already known could be a large part of the job in developing a state-wide plan for nursing education.

6. Establish at the outset a timetable for developing a plan for nursing education, and make every effort to adhere to it. Gained momentum can be lost if a planning study drags on and on.

7. Do not view planning for nursing education as a one-time matter. Provide a means for updating your studies to take into account changes that inevitably will occur.

Planning is a continuous process, and the lot of the planner is an uncertain one at best. There is risk in attempting to plan, but I am convinced that there is greater risk in not making the effort at all.

L U N C H E O N A D D R E S S

COMPREHENSIVE COMMUNITY NURSING -- CHAOS OR CHALLENGE

by

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Everyone is aware that the world population is increasing rapidly, and that the increase is greatest among those peoples with the least ability to educate and to care for themselves. The affluent nations will have to share trained manpower in all fields with "have-not" countries. In the United States, the concurrent shifts to urbanization and automation are filling metropolitan areas with vast numbers of semi-skilled workers while the job market demands higher levels of education and skill. Our educational level is rising with each generation, and improved communications keep even the poorly educated aware of every scientific landmark from space probes to heart transplants. We have a more informed, and therefore a more demanding, population. Today our citizens expect and demand complete efficiency -- plus a few miracles -- in health care.

The knowledge explosion of our technology has expanded the scope of health services in prevention of disease, in care of the acutely ill, and in rehabilitation. This technological advance has also opened a veritable "Pandora's Box" of new careers in business, in industry, and in health. Nursing must compete with a variety of new, service-oriented careers, for both men and women, many of which did not exist five years ago.

Another trend of our time is the growing importance of health as a political issue. Political concern is reflected in appropriations. Funds from the Federal government have flowed freely for some categories of services and programs. Too often this has resulted in programs not necessarily based on community need or request. We have had a wide variety of crash programs, some successful and some of questionable value. Programs and agencies have sprung up like mushrooms, with little concern for need or recognition of duplication in existing services. Still, with the proliferation of programs and agencies administering them, there remain vast segments of our population with inadequate health

services. Many people find health services inaccessible and of less than desirable quality. Health services have been fragmented by geography, by socioeconomic factors, and by monies available.

Nursing has been caught up in this fragmentation. "Categorical funding" has led to "categorical planning," with our health future routed to follow available dollars.

Panaceas for our ills and fads in our fashions have sprung up. Comprehensive planning -- in health, urban development, and other areas -- is in vogue now. To some, P. L. 89-749 -- or the "Partnership in Health" comprehensive health planning legislation passed last year by the Congress -- is the panacea for all our ills. I disagree. I believe this legislation affords a new and much needed impetus toward sound planning which can give direction to health program development. Development of a plan, however, is only the beginning. Planning is a continuous, dynamic process of exploring avenues and alternatives to achieve goals. The plan only affords guidelines and directions. There must be continuous assessment, testing, and evaluation in relation to society's changing needs and updated scientific knowledge and technical development.

What is comprehensive health planning? What do we mean by comprehensive community nursing? Comprehensive by what measures? And whose? What is a community? What is health? What is "nursing?" I do not have all the answers. I have some concepts and beliefs about comprehensive health services and about the responsibilities and opportunities for nursing to make a contribution.

The opening statement of Health Is A Community Affair, the report of the National Commission on Community Health Services, states: "Health services operated to meet the health needs of every individual should be located within the environment of the individual's home community. This concept is generally agreed upon today. Agreement on what constitutes 'a community' is not so generally accepted."

The Commission suggests that "where health services are concerned the boundaries of each community are established by the boundaries within which a problem can be defined, dealt with, and solved."[1] It presents the concept of a "community of solution," or environmental health-problem sheds and health-service marketing areas, as a base for the planning, organization, and delivery of health services.

Health services, as defined by the Commission, fall into two broad, closely related categories: personal health and environmental health.

Comprehensive personal health services embrace the health needs of all age groups; the full range of activities and techniques directed toward health maintenance, prevention, diagnosis, treatment, and rehabilitation; the identification of groups needing intensive or special attention; and continuous study and evaluation to redirect services or establish new programs as needs and resources change. This demands that we develop an interdependent working partnership with all groups interested in the delivery of and use of health services.

By law, comprehensive health planning shall be done. Society is demanding a voice in the planning and is demanding action. So planning is going to be done with or without nursing. It is up to nursing to accept responsibility and contribute. If we fail, we have no one to blame but ourselves.

Marion Sheahan, speaking to state nursing directors in Washington in September of 1967, said that personal health services should be acceptable, accessible, and available, and that nursing's greater responsibility is in the acceptability of services. Nursing also has a part to play in <u>planning</u> for the availability and the accessibility of services.

Nurses have a responsibility to participate as informed citizens interested in the total health care needs of people. We cannot, and should not, approach the planning table with the narrow, vested interests of a discipline. Again in the words of Miss Sheahan, we should participate "as co-equals, as citizens with special competence,"[2] whose background is nursing. We must not stand by idly wringing our hands until we are invited.

Instead, nursing must present a united and enlightened front. We must establish realistic nursing goals, develop plans of action to achieve these goals, and present them in the give-and-take of health care planning. This done, with a demonstrated willingness to be flexible, will win an invitation to the planning table. In short, nursing must <u>plan for nursing</u> in the context of community needs and in collaboration with others so that all planning is coordinated. Nursing is a necessary and vital part of the whole.

Comprehensive community nursing is an integral part of comprehensive community health. No plan can be comprehensive if any group or service is by-passed. I believe that comprehensive community nursing is achievable in the future. I believe that sound planning at the community level is the beginning step. Without it we will have chaos.

We will have chaos if nursing fails to assume its responsibilities and refuses to become an equal partner in planning. We

will have chaos if nursing clings to the past, holding to ritualistic practice and "sacred cows," refusing to relinquish to others the tasks that can easily and safely be performed by them -- just because "we've always done things this way."

We will have chaos if nursing continues to hold to tradition and refuses to face the reality of social change, the advances in automation, technology, and scientific development.

We certainly will have chaos if nursing continues to be a fragmented discipline and to spend endless hours of useless debate on the best way to prepare practitioners. Instead we should be discussing realistic assignments and safe and effective utilization of existing manpower to meet the nursing needs of our citizens.

The great challenge to nursing is to become an effective force in eliminating and preventing the factors contributing to chaos. Effective utilization of existing resources and sound planning for the future are essential.

Individual nurses throughout the nation need to make a commitment that "the nursing needs of the people will be met." What are nursing needs? How do we determine the nursing needs of people? I doubt there will ever be one final answer to those questions. As nurses, professional colleagues, and citizens explore these questions we will modify and expand concepts, conceive new delegations of functions, and discover new possibilities for fostering independence and self-care. We can make a firm commitment to the concept of comprehensive nursing care; continuity of care will then become a reality.

Nurses, individually and collectively, must take a much stronger leadership position in this continuity component of health care. Jane Keeler, executive director of the New Haven, Connecticut, Visiting Nurse Association, said at the 1967 NLN convention, "Communications among nurses serving in in-patient services, those in extended care facilities, in community health centers, and in patients' homes must be opened up, if we are to be truly effective. Nor should we cease our efforts to stress the importance of continuity in planning patient care services and care for the individual patient. Too often gains made in helping the patient move toward independent functioning through rehabilitation are lost or deterred when appropriate follow-up services are not provided on the patients' return to the community."[3]

Nursing service is challenged today to provide more nursing care to more people in more places. In planning for the delivery of this care, we face the reality of manpower shortages and, at

the same time, grapple with the issues of quality and safety. Some seem to think nursing problems can be solved by numbers. We know that additions of untrained workers make good supervision more essential. How can we stretch services of the professional nurse? How can we utilize the skills and abilities of personnel from different educational programs? What tasks can be delegated? How far can we go in adding untrained workers and still provide safe care? These are our challenges in service.

The issues of quality and safety as they relate to staffing and delivery of nursing care demand planning, study, and communication. They also demand creativity, imagination, and flexibility. Decisions must be made and priorities established. Traditional patterns of organization and staffing do not meet the needs for care in today's rapidly changing and increasingly demanding health services. Innovative staffing has to be devised -- day before yesterday! Doris Schwartz has described the dilemma so aptly when she said, ". . . American nursing has changed so rapidly that in many ways it has left us knowing better than we do; and in other ways, the speed of certain kinds of technological change, and the changed distribution of the consumers of top-notch health care, has left us <u>doing</u> without really knowing how."[4]

She also gives a beautiful description of the leadership of the professional nurse in team nursing. "Not fragmented nursing," she says, "but nursing which binds together, in a bond of common concerns" for the best interests of the patients and families.

Team nursing is one direction for the future. We must think of other ways to utilize and extend the expertise of the best prepared nurses for the benefit of patients. We cannot hold rigidly to traditional and ritualistic practice.

Nursing education is challenged to prepare more nurses to perform in a rapidly changing health care system. Courageous action is needed now to prepare nurses for the future in both the quantity and quality which will be needed. Let us define and recognize the essential differences in the character, level of education, and the individual abilities and functions for which nurses should be prepared, and recruit students into appropriate programs. We need expertise in technical skills and in critical independent thinking. Future nurses need to be taught not what to think but how.

Mary S. Tschudin, in an article appearing in the April, 1964 <u>Nursing Outlook</u>, said that "education too often follows existing practice rather than creating a new base for tomorrow's practice."[5] It seems to me that she is challenging nursing educators to more research and more thinking.

The shortage of qualified faculty is one of our major dilemmas. Are there ways to extend faculty? Could schools of nursing -- all schools -- cut out competition and rivalry and plan constructively how, together, they might make more effective use of faculty and expand the student body? The quality of instruction also might be improved.

Continuing education is another challenge. The concept of continuing education is not generally accepted in nursing. We need to encourage it. If programs are developed which are geared to the needs of practitioners, demands for continuing education will increase.

Nursing education needs to re-think its relationship to nursing service, and this is a two-way street. More intensive efforts must be made to share in the planning for, and realistic use of, clinical facilities for student practice. Resources for student learning experience should be re-evaluated in view of changing patterns in delivery of care. Perhaps nursing service may be of help to education here.

Nursing education can help nursing service, too, in planning for the transition of the young graduate from the role of student to that of practitioner. The new practitioner sometimes has unrealistic expectations of service agencies and is not prepared to cope with service loads. Nursing service agencies are not always realistic in their expectations of performance of the beginning practitioner. In facing unrealistic demands and assignments, young graduates become frustrated. They either move out of nursing or adopt the pattern of practice which they see as a role-model. Nursing service does not always present the image of an expert practitioner. The maverick is not always welcomed in our usually traditional, unquestioning, conforming, and compliant nursing population.

Nurses, doctors, hospital administrators, and the community must change attitudes. Here nursing leaders must exert more effort. Here we need community support. We must interpret more effectively our concerns and beliefs and be willing to go the second mile in efforts to communicate with our professional colleagues and community groups.

If nursing can define more precisely the levels of practice and interpret these to community leaders, we will gain their assistance in support of nursing education and their help in recruitment. We will also recruit from a wider segment of the population. I should like to see us place more emphasis on recruitment, into associate degree programs, of young housewives and older ones whose children are in school. Maturity would be an

asset to the student in an accelerated program.

Have we explored as fully as we should pre-nursing school tutorial programs to help boys and girls whose educational backgrounds are weak or perhaps lacking in necessary subjects? Correcting these deficiencies would provide more suitable candidates for nursing. There are Federal funds available for such assistance to the educationally disadvantaged. We will need the help of our educational systems and financial support of the community to develop these programs.

Recruitment might be greatly enhanced if we could identify the factors which motivate boys and girls to enter such programs as the Peace Corps. The motivations toward this helping career may throw some light on recruiting for nursing.

How can we attract more men into nursing? What are the deterrents which discourage male practitioners? Has nursing established a closed society?

These challenges are particularly pertinent to this region where the nursepower situation is critical. Nursing must take determined and decisive action to meet more adequately the needs for care. Community planning for nursing is the answer.

Comprehensive community nursing is an achievable and desirable goal. Planning must be all inclusive and flexible. It must be a partnership with community health planning. Nursing must be firmly committed, willing, and determined to succeed and infected with "divine discontent." Then we cannot, and shall not, fail!

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T H E I S S U E S

To begin the conference work sessions, regional advisory teams set about to identify issues pervading nursing service and nursing education, the data needed in order to decide the issue, and the factors which help or hinder its resolution. Representing a cross section of the nursing interests and the states present at the conference, these groups fed the results of their deliberations into the state teams. State teams were then free to pick one of the issues so identified, to select another, or to combine several for discussion and resolution in their recommendations for state action.

Here are the points and questions the regional advisory teams identified as nursing issues in the South:

Nursing Service Issues

1. Manpower

   Levels of personnel.

   Who is responsible for preparation?

   Recruitment and retention of staff.

   A shortage related more to utilization than numbers.

   Large numbers of underprepared workers.

2. Administration

   Should the administrator of a nursing service be a nurse?

   Conflict in philosophy between administration and staff.

   Need for agreement about job descriptions and functions.

3. Nursing Personnel

   Nurses do not wish to give up non-nursing functions.

Conflict between career orientation and actual job responsibilities.

Nurses' ambivalence in incorporating new technologies and new technicians into nursing care.

Attitude toward utilization of part-time workers.

Resistance of some registered nurses to licensed practical nurses; some public health nurses to home health aides.

4. Community Concerns

Delivery of nursing care.

Continuity of care.

Economics of health care related to poor utilization.

What standards will permit delivery of nursing care to all who need it?

Lack of communication among health workers in the community.

5. Nursing's Image

Use of the term "nurse" in titles of workers who are not necessarily nursing.

Definition of nursing.

Recognition of role of the nurse.

Salaries, working conditions, fringe benefits.

Discrepancy between layman's and nurse's concept of the nursing role.

6. Some Factors Affecting Nursing Education

Need for quality care criteria before education is planned.

Pre-service preparation of associate degree graduates to function in public health agencies.

Closer relationship and collaboration between

service and education agencies.

Closer interaction between student and service agency.

Nursing Education Issues

1. Faculty

Why nurses enter other fields for graduate study.

Can schools share faculty?

Are salaries attractive enough?

Selection.

Attrition factors contributing to faculty shortage.

Use of faculty assistants.

Utilization of faculty.

Should faculty work hours other than 8:00 - 5:00?

Sabbaticals.

Are teachers and administrators good role-models for students?

Inservice and continuing education.

2. Students

Recruitment.

Selection methods.

Factors influencing attrition.

Counseling into appropriate programs.

Sources of information about nursing.

Special problems of registered nursing students.

How can the community and parents be informed about nursing?

3. Educational Programs

Are objectives of the various types of programs clear?

Is baccalaureate education too expensive?

Image of nursing education.

Should all programs of the same type be the same length?

How to best utilize clinical facilities -- 24 hours a day?

How to select learning experiences.

How to evaluate curriculum patterns.

Transfer credit between programs.

Are "career ladders" appropriate in nursing?

How communities can evaluate the need for new programs.

Should all types of programs have the same foundations?

Preparation of students for special practice below the masters level.

How to evaluate student learning effectively.

4. Licensure

What are its true purposes?

Are examinations appropriate?

Do examinations reflect current practice?

5. Issues Related to Nursing Services

Preparing students for the reality of practice.

How beginning levels of practice are defined.

How graduates are selected for positions.

Utilization of graduates of different types of programs.

Are graduates of different types of programs paid on the same basis?

Do nursing education and nursing service subscribe to different philosophies?

T H E S T A T E S A T W O R K

As state teams delved into the issues they selected, it became evident that the conference theme, "citizen planning for nursing," permeated their thinking. This was noticeable especially as they identified the groups and individuals in their states who are or should be involved in developments in nursing education and nursing services. So numerous were these and so similar from state to state that they have been compiled into a comprehensive list and appear at the end of this section on page 53. The list is a reminder of the variety of persons, groups, and organizations, from both the public and private sectors of the states and communities, with a stake in planning for nursing and health services.

As the state teams worked, they not only discussed issues and proposed solutions but charted ways and means of arriving at these solutions before formulating statements of commitment and concern. For the purposes of this report, the total work of each state team is briefed rather than reported in full. Each state team has taken back to its constituent league for nursing and other appropriate groups in the state the detailed action suggestions and decisions they arrived at in Atlanta. Although these may be considered anew and refined further before being implemented, the methods they suggest convey a variety of approaches to meeting nursing needs in the Southern states into the 1970's. The following "state stories" are syntheses of the issues, proposals, and commitments of the state teams of the 13 states meeting at "Operation Decision: Citizen Planning for Nursing in the South."

Alabama

Alabama selected as its nursing service issue: Utilization of workers, both the fully qualified and the less-than-fully-qualified. Among the solutions the group proposed for nursing services were the development of new patterns of care, and defining the expanding roles nursing is experiencing in order to meet consumer demands.

As its nursing education issues it chose (1) recruitment and (2) obtaining and retaining qualified faculty. The team suggested the use of students as faculty assistants, resolution of the

problem of transfer credits from program to program, sharing faculty, and more uniform faculty personnel policies among schools in the state.

In concrete terms it stated that if Alabama is to have adequate nursing services in the 1970's, these issues must be confronted:

Better utilization of all levels of personnel.

Wider recruitment for all types of programs in nursing.

Improvement in quality of basic education.

Higher standards and more uniform personnel policies among employing institutions.

It recommended that the following actions be begun or continued:

a. A broadly representative state planning committee to meet nursing needs in both service and education be formed.

b. The Alabama League for Nursing obtain grant funds to sponsor a workshop on utilization of personnel.

c. The University of Alabama be asked to offer courses in continuing education for nursing.

d. Recommendations coming out of a study on nursing needs in Alabama, currently underway, be considered for future directions.

Arkansas

Arkansas chose utilization of personnel as both its nursing service and nursing education issue. Inservice education programs, workshops, and better interpretation of nursing to the public, all were seen as contributing to the attainment of adequate nursing in the state in the 1970's.

The Arkansas team recommended that spearheading planning for nursing in the state be a joint activity of the Arkansas League for Nursing and the Arkansas State Nurses' Association through a joint committee on state planning for nursing.

It proposed as action to be taken the formulation of a

master plan for the utilization of personnel in the state. The team envisioned that this plan would provide for full-time study staff, data collection, the use of task forces, and implementation of the plan.

Florida

In stating its nursing service issue, the Florida team asked: "Are published standards of nursing service being implemented in hospitals, nursing homes, public health and other agencies?"

Its nursing education issue it phrased as: "Are educational resources known and utilized for pre-employment and continuing education of personnel?"

This team's concern for standards to facilitate the delivery of safe and comprehensive health services led it to constitute itself as an unofficial committee to prepare and present a proposal to the Florida League for Nursing board and membership. This proposal would include a plan and timetable for a program to implement standards of nursing service in hospitals, nursing homes, and other agencies providing health care in the state.

Georgia

As the host state for the conferences, Georgia had the largest state group in attendance, and this divided into three teams. Their nursing service issues were delivery of patient care, with special attention to continuity of care, and how to use various kinds of nursing personnel.

In exploring these the teams proposed that a system of providing continuity of care be developed in concrete terms and that a state-wide plan be initiated to effect this system. They saw the need to provide for horizontal as well as vertical advancement in nursing, to delineate responsibilities of specific levels of personnel, to utilize nurses according to preparation, to educate the public, and to develop a master plan for nursing in the state.

As nursing education issues the teams chose national licensure of nurses, delineation of the educational objectives of the various programs in nursing, and utilization of faculty and of educational resources in the state.

The team considering national licensure noted that the climate would have to be right for so radical a change from state to national licensure and suggested several means by which a climate of

acceptance might be created. Those exploring the definition of objectives and utilization of faculty and resources had a variety of approaches to suggest, among them: sharing faculty, support of students going to other states to prepare for teaching, development of a glossary of the levels of nursing personnel in Georgia, and evaluation of the efficiency of educational programs in the state with a view to shortening them.

As a total group the teams recommended that the following actions might begin or continue in planning for nursing in Georgia:

a. Support of the Georgia Education Improvement Council nursing study, currently underway.

b. Initiation of a vigorous public information program with special emphasis on scholarships.

c. Formulation of a positive position of nursing's relationship to the Health Careers Council of Georgia.

d. Encouragement of nursing participation in comprehensive health planning.

e. Appointment of a Georgia State League for Nursing committee to study and implement continuity of care.

Kentucky

Better utilization of registered nurses in modern health care was the nursing service issue selected by Kentucky. Interpretation and implementation of "modern" health care, however, they saw as one of the first steps to be taken. This should involve nursing personnel, patients, other citizens -- i.e., the whole community. They also recommended widespread community involvement in comprehensive health care planning, and suggested that a Governor's commission on nursing would be an appropriate and helpful agency to have in the state.

Kentucky's nursing education issue was the need for new nursing programs in the state, with a masters program singled out especially. The team urged that the work of a blueprint committee for nursing education in the state, which is now underway under the aegis of the Kentucky State Nurses' Association, be continued. They wished, however, to involve the community more widely in discussions and decisions about nursing education.

The group recommended that the Kentucky League for Nursing form a committee to initiate action which will involve citizens of the Commonwealth in health care planning. They recommended disseminating information about health careers throughout the state and bringing all health groups together in a joint state-wide recruitment effort for health manpower.

Louisiana

The state team selected recruitment and retention of staff as its nursing service issue, proposing the following among its solutions: refresher courses to return inactive nurses to active employment; coordinating continuing education programs; sharing information with employers about working conditions, inservice and continuing education needs; and providing realistic guidelines to minimum safety of patient care.

Increasing the opportunities for higher education in Louisiana was the education issue developed by the team. The group proposed that a masters program in nursing be established in the state and that baccalaureate programs be more flexible in admitting registered nurse students. They suggested more opportunity for part-time study by practicing nurses wishing to work toward a bachelors degree, more sources of financial assistance for these students, and reassessment of the methods of determining advanced standing in baccalaureate programs.

As a first step toward opening up more educational opportunities in Louisiana for registered nurses, they recommended that the state's nursing organizations jointly call a meeting of deans and directors of nursing programs to discuss this and related problems.

They also recommended the formation of an official state committee or commission on nursing.

The Virgin Islands representatives joined the LLouisiana team in their discussions and work sessions.

Mississippi

A state-wide study of nursing is just getting underway by tthe Educational Research Committee of the Board of Trustees of Institutions of Higher Learning. The Mississippi state team reserved decisions about major issues in nursing until the recommendations of this study are known.

Manpower was the issue they selected for discussion for both

nursing service and nursing education. As much of the nursing data being compiled for the state-wide study relates to manpower, the state team indicated that the best course of action for nursing in the state at the moment is to continue to support and cooperate with the survey team and its advisory council. The latter, composed of deans and directors of the state's schools of nursing and the executive secretary of the Board of Nurse Examiners, is identifying the criteria for quality in each school's program.

They urged that the citizens of the state be made aware of the recommendations of this study, when available, through widespread dissemination of its findings.

North Carolina

As a result of its ongoing studies of nursing education, North Carolina has state-wide planning underway for this aspect of nursing. Its state team selected as its nursing services and nursing education issues how to use to best advantage in health services the people who have had some health preparation -- discharged military personnel, licensed practical nurses and aides, inactive health personnel, administrators in other fields who can be trained for hospitals and other health services, and drop-outs who have not completed a basic program in the health field.

As one approach to this problem, the state team suggested that the Governor's Office of Comprehensive Health Planning be asked to appoint an official committee or commission to consider this health personnel potential. Included in this suggestion was employment of personnel to carry out a state-wide project on the utilization of all available health personnel.

The team also suggested that the National League for Nursing explore the possibility of examinations which would test at any level and thus stimulate transition from one level of nursing education and practice to the next. They proposed that the North Carolina Board of Nursing consider assuming this responsibility if national efforts proved not to be feasible.

The state team indicated its future actions would be to recommend that:

a. The North Carolina League for Nursing establish a mechanism for calling together deans and directors of schools of nursing, on a regularly planned basis, to consider sound educational approaches to meeting manpower needs in nursing, especially

to consider upward mobility.

b. Consideration be given to calling together administrators of nursing service and nursing education to explore mutual problems on a planned basis.

South Carolina

South Carolina's team selected its nursing service issue from those identified by the regional advisory teams -- i.e., the establishment of criteria of quality care before education can be planned. It cautioned that criteria for quality must include both safety and effectiveness. As one approach, it proposed that comprehensive health planning include the recipient of services as well as the giver.

If adequate nursing services are to be assured to the people of South Carolina in the 1970's, the state team indicated that these matters must be considered: adequate utilization of nursing personnel who are available and working, quality care that exceeds the minimum for safe practice, high-quality education programs in nursing, recruiting both men and women into the field, and securing and holding qualified faculty in nursing schools.

For nursing education, the team viewed the acquisition and effective utilization of competent faculty for all programs in nursing as an overriding issue. It looked also to state-wide planning for the placement and establishment of schools of nursing.

It urged that an approach be made to the Governor to establish a commission on nursing -- to include representatives of nursing, labor, education, and civic groups -- "with the responsibility of planning and implementing effective measures to insure both safety and quality of nursing care to the people of South Carolina."

Tennessee

Nursing's role in health care -- specifically in assessing, implementing, and evaluating health care -- was the prevailing concern of the Tennessee state team. In selecting this as its nursing service issue, the team indicated that the attention of the state government should be brought to this matter and official assistance sought in resolving it. They indicated that although nurses should be represented adequately in any such effort, solution to the problem required participation also from allied professional, consumer,

and health care planning groups.

As their nursing education issue, the team pursued the inadequacy of prepared faculty, especially in programs preparing students to become registered nurses. They proposed that this problem be presented to the state Commission on Higher Education for investigation and resolution.

They recommended the following actions in planning for nursing in Tennessee:

a. Interpretation of the Tennessee Nurse Practice Act.

b. Planning for health care on a comprehensive, coordinated basis.

c. Intensified recruitment for nursing.

d. Programs to bring inactive nurses back into practice.

e. Extension of the consultation services of the board of nursing.

f. Identification and utilization of health care planning bodies.

The team assumed responsibility for beginning the preparation of a statement on the role of nursing in assessing, implementing, and evaluating health care and of writing a letter to the state board of nursing requesting extension of their consultation services. They recommended that the Tennessee League for Nursing Board of Directors, or possibly the coordinating council of the league and the state nurses' association, ask the Governor to establish a commission on nursing. This commission would identify the levels of nursing personnel needed and the numbers required at each level, and make recommendations concerning the implementation of the role of nursing in health care. The team asked that the League offer its resources to such a commission.

The Puerto Rican representative participated in the work of the Tennessee state team.

Texas

The Texas team selected utilization of manpower as its nursing service issue, and education for optimum utilization as its nursing

education issue.

Its proposed solutions and approaches centered around working through established coordinated planning groups such as the Joint Executive Committee on Nursing Needs and Resources for the State of Texas, sponsored by Texas nursing organizations, and the Governor's Comprehensive Health Planning Committee.

The group stated its belief that more effective use would have to be made of all health manpower if nursing needs are to be met. State-wide planning and coordination for education must be ongoing and include inservice education and continuing education, as well as formal education at all levels.

It recommended that the Joint Executive Committee on Nursing Needs and Resources:

a. Establish guidelines for ongoing exploration in depth and scope of nursing needs and resources at the local level, involving appropriate groups in collecting this information, compiling and analyzing the findings, and presenting them to the State Comprehensive Health Planning Committee.

b. Compile a list of suggested appointees to the comprehensive health planning committee "who will effectively articulate nursing needs of the people of Texas."

c. Prepare a statement of concern about the dangers inherent in too hasty development of associate degree programs in the state.

It voted to recommend further that:

a. The Careers in Nursing Committee of the Texas league and nurses' association initiate efforts to recruit ex-servicemen.

b. The Texas Hospital Association's council on nursing be asked to collect and disseminate information about innovative patterns of utilizing nursing personnel and encourage such innovations.

c. The state-wide continuing education committee just being formed encourage the ongoing compilation of available films, video-tapes, bibliographies, and other continuing education materials and that it use its offices to prevent duplication of such resources.

d. The Texas League for Nursing assume responsibility for promoting graduate nursing education in the state.

e. The Texas nurses' association and league work cooperatively to promote community planning for nursing.

Virginia

Support of Virginia's recently initiated state-wide study of nursing education led this state team to suggest a number of actions which could be taken pending outcomes of the study.

With manpower utilization as its nursing service issue, the team proposed a definition of nursing -- i.e., "nursing is an organized service to individuals and groups which helps to identify the health concerns -- mental and physical -- in sickness and health, to plan for intervention in meeting needs, to make judgments as to the appropriate intervention, and to coordinate the activities of other service personnel as these relate to the life of the individual."

The need for nursing schools to relate objectives more closely to the expectations of young people today was the team's nursing education issue. One proposal was that "tradition-bound nurses" be reoriented.

Specifically the group recommended:

a. Expanding graduate education in nursing through more financial support for students and study of the practicality of a second masters degree program in Virginia.

b. Interpreting to the public the social significance of nursing, and the need to upgrade paramedical salaries.

c. Stimulating recruitment by orienting high school counselors, establishing a central source of information about scholarship and loan funds, and recommending to the state legislature the employment of a recruiter for nursing.

d. Supporting refresher courses for nurses under health manpower projects.

e. Better medical staff understanding of nursing's problems and more active involvement in recruitment.

f. Identifying the role of various categories of nursing personnel and exploring the feasibility of career ladders.

West Virginia

"How can nursing resources be organized to meet more effectively the health care needs of West Virginians?" was the issue this group selected for both nursing service and nursing education.

Its answer -- comprehensive health planning.

Comprehensive planning, said the group, should be based on these principles: A health care focus on the patient and his family, coordinated comprehensive health care, and the regionalization of resources. It should aim toward bridging the gaps in recruitment, utilization of workers, provision of upward mobility, and evaluation of progression toward goals.

The dearth of health services in large portions of the state resulting from population loss and a consequent loss of health workers led the team to suggest that unique and interesting nursing service projects are needed to attract leadership. It recommended that a master plan be projected for nursing education, that there be state-wide recruitment efforts, and that planning for upward mobility in nursing be undertaken in the state.

Noting that a report of the Governor's Task Force on Health would be presented shortly at the West Virginia league convention, the state team recommended that following steps include in-depth analysis and interpretation of the data from this report and development of a plan of action based upon this analysis.

A committee of the West Virginia league and nurses' association has collected data about nursing and health needs for this study in the state. The team recommended that the committee seek financial and technical assistance in analyzing the study data from the Regional Medical Program.

W H O ' S I N V O L V E D

I N S T A T E - W I D E P L A N N I N G F O R N U R S I N G

Individuals -- Agencies -- Groups

Identified by the Participants in
"Operation Decision: Citizen Planning for Nursing in the South"

Government

Comprehensive health planning council
Public Health Service regional office
Regional medical program official

State board or commission of higher education
State board or department of education
State board or department of health
State board of nursing
State committee or commission on nursing
State department of labor
State department of vocational education
State governor or representative
State legislature
State licensing bodies for all health personnel
State university
State university board of supervisors

Military separation centers
"Upward Bound" program - Office of Economic Opportunity

Voluntary Organizations

Careers committee (nursing)
Civic groups
Commission on hospital care
Council on health facilities
Education improvement council
Health careers council
Health council
Health planning council
Heart association
Hospital association

League for nursing
Medical care commission
Medical society
Mental health association
Nurses' association
Nursing homes association
Parent-teacher association
Practical nursing association
Tuberculosis and respiratory disease association

Individuals

Consumers of nursing
Deans and directors of nursing schools
Educational telecasters
Educators
Employers of nursing personnel
High school counselors
Industrialists
Labor leaders in the community
Lay leaders in the community
Leaders in nursing
Management consultants
Nurses
Out-of-state representatives
Paramedical personnel
Physicians
Research specialists

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Durham

Vice Chairman: Mrs. Frances O. Browder
President, Alabama League for Nursing
Birmingham

Secretary: Ruth B. Melber
President, Georgia League for Nursing
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1967 - 1969

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Department of Public Health Nursing
National League for Nursing

END

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